

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-002525

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 30

STATE FILE NUMBER

FILED FEB 1 1963

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>MARION</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>LANNIBAL</u>		Length of stay in 1b <u>46 YRS</u>	c. CITY OR TOWN <u>LANNIBAL</u>
c. FULL NAME OF (If NOT in hospital, give location) <u>LEVERING HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>212 N. GRIFFITH ST</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ORIS POWERS</u>		4. DATE OF DEATH Month Day Year <u>JAN 28 1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 27 86</u>
9. AGE (last birthday) <u>76</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INTERNATIONAL SHOECO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAVERTON, MO.</u>	
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>DAVID W. POWERS</u>		13b. MOTHER'S MAIDEN NAME <u>KITTURRAH FORD</u>	
14. NAME OF HUSBAND OR WIFE <u>LENA POWERS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES 1906-1914</u>	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>LENA POWERS - LANNIBAL MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTASES - DIFFUSE</u> DUE TO (b) <u>ANAPLASTIC CARCINOMA</u> DUE TO (c) <u>OF PROSTATE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>URINARY TRACT BLEEDING</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at <u>11:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John F. Clahan M.D.</u>		22b. ADDRESS <u>BXL BUILDING</u>	
22c. DATE SIGNED <u>1-29-63</u>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 30, 63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GRAND VIEW CEM. LANNIBAL, MO</u>	
23d. LOCATION (City, town, or county)		23e. DATE RECD. BY LOCAL REG. <u>JAN. 29, 1963</u>	
23f. REGISTRAR'S SIGNATURE <u>Dr. E. M. Locke, Jr. William M. Thomas</u>		23g. FUNERAL DIRECTOR <u>CLARK FUNERAL HOME - MO.</u>	

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4217

P. O. Address San Antonio, Tex

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

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Permit issued 11/29/63